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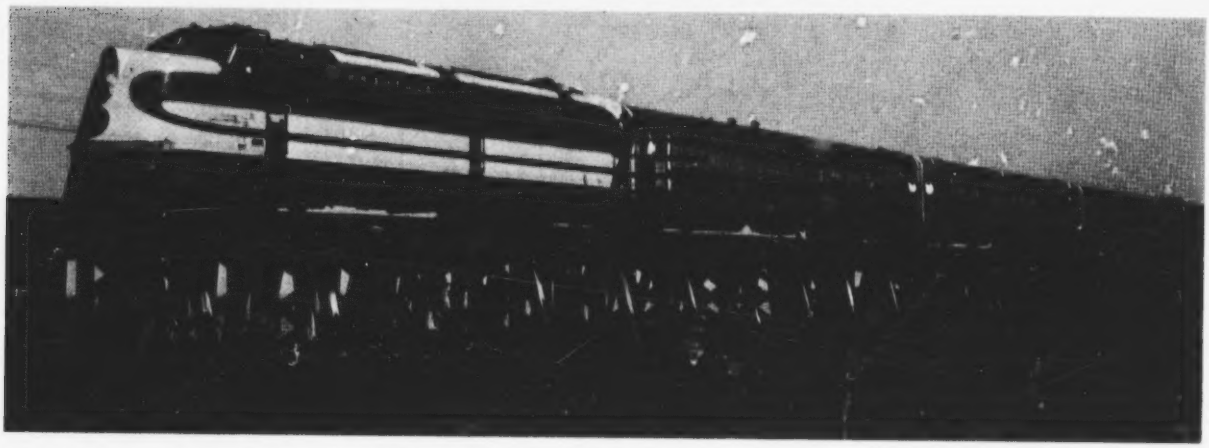
CROSSING THE LINES AND CLOSING THE GAPS

CRITICAL ISSUES IN MAINSTREAMING WORKERS WITH DISABILITIES: AN INTERDISCIPLINARY APPROACH TO THE MEDICAL/VOCATIONAL REHABILITATION PROCESS



Crossing the Bridge with Education, Rehabilitation, Placement and Employment

Report of a Conference Sponsored by the President's Committee on Employment of People with Disabilities (Medical Subcommittee) and the California Governor's Committee for Employment of Disabled Persons

October 8-9, 1986
Los Angeles, California

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Index

Program Participants---------- i - iii

Introduction---------- v

Welcome---------- vii

Setting the Stage-
- Speakers---------- 1
- Abstract---------- 3
- Presentations---------- 5 - 11

The Players and Their Strategies-
- Speakers---------- 13
- Abstract---------- 15
- Presentations---------- 17 - 25

The Mechanisms-
- Speakers---------- 27
- Abstract---------- 29
- Presentations---------- 31 - 40

Feelings-
- Speakers---------- 41
- Abstract---------- 43
- Presentations---------- 45 - 47

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Introduction

The Conference held in Los Angeles in October 1986 is the third in a series sponsored by the Medical Subcommittee of the President's Committee on Employment of People with Disabilities in selected parts of the United States. The first was gathered in Green Bay, Wisconsin, and the second convened in Chattanooga, Tennessee.

The objective has been to highlight various aspects of the ongoing effort of bringing into gainful employment persons with the residua of illness or injury, or individuals who have been challenged by limiting congenital or developmental anomalies.

In the Los Angeles meeting, the intention was to bring together those medical and vocational rehabilitation professionals who play significant roles in preparing persons with disabilities for the contemporary working world. Employment opportunities will multiply only if these specialists know the functions of one another so that they can contribute in concert toward a common goal.

By a discussion of today's economics, the pertinent legislative mandates, the participating professionals, the mechanisms involved, and the feelings of people with disabilities, it was envisioned that clearer understandings of the total rehabilitative process would result. It is only through the initiation and continuation of communication among concerned participants that goals can be reached. The Los Angeles conference was a step in that direction.

We are greatly indebted to Jean Spencer Felton, M.D. for the many hours of work spent in organizing the Conference and writing the text of this report from the recorded presentations. The text was faithfully transcribed by Chris Jasiewicz at the Southern Occupational Health Center, University of California, Irvine; and we thank her.

Paul S. Entmacher, M.D.
Chairman, Medical Subcommittee
of the President's Committee
on Employment of People with Disabilities

Welcome

The conference was opened by Mr. Harry Servidio, Chairman of the California Governor's Committee for Employment of the Handicapped who, in addition to welcoming those persons attending, cited data from the recent Lou Harris poll of people with disabilities in the United States. He indicated certain of the findings wherein 66 percent of people with disabilities who were not working expressed the desire to work; 47 percent of the group that was employed either had experienced discrimination at some time in their pasts or believed that they were working below their potential.

Mr. Servidio believed that we had possibly become complacent in the past regarding the employment of persons with disabiiities, when actually much more needed doing to allow such persons to attain fulfillment through gainful employment. It is hoped that were another poll to be taken in the future the responses would reveal greater success in work placement.

The Director of California's Department of Rehabilitation, Dr. Cecie Fontanoza, in welcoming the attendees, emphasized that the inability of persons with disabilities to find jobs has become critical. Society expects everyone to work and, as it is known commonly, we measure individual worth by the work one accomplishes. It must be our goal to allow persons with disabilities to reach their maximum potential in the most productive and least restrictiw environment. As President Reagan has indicated, people with disabilities want to contribute to the progress of the community and the 1980s should provide the greatest access to society and the maximum opportunities for people with disabilities to use their capabilities. We must eliminate antiquated perceptions of people with disabilities; the barriers of prejudice, fear, ignorance, and false assumptions are more difficult to break down than were the physical barriers encountered in the past.

Several companies, e.g., Safeway Stores, IBM, Hyatt Hotels, and the Federal Government, among others, have shown considerable success in the employment of persons with disabilities, and certain organizations have taken strides in the accommodation of such workers. But the mission remains of satisfactorily filling the gap between the job needs of the applicant with a disability and the worker needs of the employer.

The record of the state's Department of Rehabilitation has been outstanding. In the last three years, 48,000 Californians with disabilities were returned to work, and in the most recent 12-month period, 17,000 individuals were rehabilitated, representing a 23 percent increase since 1984.

Catherine Baird, speaking for Mr. K.R. Kiddoo, Director of the California Department of Employment Development, emphasized the need for the professionals engaged in rehabilitation to become familiar with the roles and contributions of the other disciplines engaged in the rehabilitative process. Trained as we are in our singular sprcialties, we narrow our thinking and our activities when there must be a sharing of different bodies of knowledge, stemming from diverse areas of practice. This educative crossing of interdisciplinary lines is the true objective of the conference.

SECTION I

SETTING THE STAGE

Co-facilitator Melinda Wilson, Assistant Deputy Director, State Department of Rehabilitation.

Today's World of Work—Changes in Demography, in Technology, in the Economy, in Management. Craig Galbraith, Ph.D., Assistant Professor, School of Business, University of California, Irvine.

The Legislative and Case Law Bases for Rehabilitation at the Federal and State Levels; Worksite Modification. Charles W. Fleming, Chief, Community Access Rehabilitation Section, State Department of Rehabilitation.

Co-facilitator Paul S. Entmacher, M.D., Senior Vice President and Chief Medical Director, Metropolitan Life Insurance Company, Chairman, Medical Subcommittee of the President's Committee.

Preparing Youth With Disabilities for the Job Market

The Secondary Level — Jane Lugo, M.A., Advisor to the Work Ability Program, Los Angeles Unified School District.

The University Level — Paul K. Miller, Ph.D., Director, Handicapped Student Services, California State University, Fullerton.

Identifying the Opposition — Where are the Roadblocks? Marilyn Holle, J.D., Senior Attorney, Protection and Advocacy, Inc.

SETTING THE STAGE

ABSTRACT

The first section reviews today's world of work - its demography, its technology, its economy and its management - as a setting in which to visualize the placement of persons with disabilities now and in the future. It was pointed out that enactment of laws furthered and made possible the utilization of persons with disabilities, such as The Federal Architectural Barriers Act of 1968 and the Rehabilitation Act of 1973, from which came the term "reasonable accommodation." The essence of Section 504 of this legislation is that one cannot discriminate against a qualified person with a disability who can perform the essential functions of the job with reasonable accommodation.

The second section has to do with preparing youth with disabilities for the job market and discusses a Project Work Ability program in Los Angeles. This unique program, designed with linkages with the Department of Rehabilitation, Employment Development Department and local school district personnel, proved that youth with disabilities can function effectively in the workplace. The same was true at the university level. The final section is devoted to roadblocks that tend to prevent persons with disabilities from being gainfully employed.

Setting the Stage

Craig Galbraith, an economist, reviewed today's world of work—its demography, its technology, its economy, and its management—as a setting in which to visualize the placement of people with disabilities now and in the future. He referred to Alvin Toffler's 1980 book The Third Wave, a follow-up of his earlier Future Shock. The first movement was the agricultural wave, where the economy rested within the small family units of the time. These were the days of small government, to wit, the city-states, in addition to the small productive entity of the family.

The second wave was the industrial revolution, where the movement was to centralize and massify human effort. Government enlarged, religious bodies broadened, and educational institutions grew. Mass production, mass advertising, and mass consumption became the mode of the day. We are now approaching Toffler's third wave, termed by some as the post-industrial society or the information age which will demand dismantling of the huge institutions created in the second wave. There must be a return to a decentralized society for survival.

From a position of leadership in the arts, in empire, and in law, Great Britain has, he pointed out, in 100 years, experienced economic decline. Will the same process take place in this country, declining and stagnating similarly, or will we go into the third wave?

By the year 2000, after diminishing birthrates—the highest were in the 1940s and '50s—the population will be older. The majority will be between 40 and 60 years of age. There will be discretionary income; they will have money to spend, and someone will have to provide goods for these consumers. In substance, we do not have enough workers to support our economy or to manufacture the goods that the older individuals want to buy. The result is that they will purchase items from abroad.

The retirement pattern has changed—in 1900, 4 percent of our population had retired, while projecting this figure to the year 2040, we find that 25 percent will have ceased their work life.

In order to maintain incomes relatively the same among the segments of our population, money will have to be transferred from the 20-60 year working group to the retirees, which means a move through taxation. We must produce to support this group. Old-line manufacturing is declining in the mid-West and the East, and we see it moving offshore. Only two major employment groups will persist in the future: The service industry will expand dramatically and high technology will continue to grow. The skills requiring physical labor are no longer critical in this newer economy. Key to the third wave is an intellectual economy, a transition which Japan has made successfully and upon which the United States is currently embarked.

In a survey of 400 high technology companies in Southern California it was learned that the prime criterion in attracting an organization to a locality is personnel of quality. In the past 3,000 years civilizations have risen and fallen. To clarify one example, Dr. Galbraith indicated that the Romans had art, law, and philosophy, but had no "zero," which precluded the development of engineering and those things necessary for the continuation of civilization.

Dismantling our institutions and our perceptions will be difficult but mandatory to move into the third wave. In the building of our service industry and our biotechnology, we will have much of the solution to the problem to which this conference is dedicated—the intellectual economy can and will utilize the minds, and not necessarily the bodies of its greatly needed personnel.

Charles W. Fleming of the Department of Rehabilitation, in his presentation of "The Legislative and Case Law Bases for Rehabilitation at the Federal and State Levels and Worksite Modification," continued from Dr. Galbraith's point of departure—the bulge in the population. In a mid-1982 writing in the Harvard Business Review data were presented showing that the percentages of nearly all disabilities had increased remarkably, e.g., diabetes 174 percent, hearing impairment 156 percent, and the like. This increased amount of disability means a rise in social security, workers' compensation, and dependent care payments, resulting ironically from our growing technology. Where will the labor force come from to meet these needs?

Mr. Fleming cited the various enactments which furthered and made possible the utilization of persons with disabilities: a) The Federal Architectural Barriers Act of 1968; b) the California Architectural Barriers Act of 1968; c) the California Health and Safety Code of 1970; and d) the Rehabilitation Act of 1973. From the last came the term "reasonable accommodation." In Section 504 of the Rehabilitation Act of 1973, a person with a disability is defined as any person who a) has a physical or mental impairment which affects one or more of life's major activities; b) has a record of such impairment; or c) is regarded as having such an impairment. The essence of this legislation is that one cannot discriminate against a qualified person with a disability who can perform the essential functions of the job with reasonable accommodation.

There have been numerous misconceptions; for example, one does not have to employ a blind bus driver! Mr. Fleming cited instances of reasonable accommodation and went on to explain who was subject to the requirements of Section 504: Any recipient of federal financial assistance in the form of funds, services of federal personnel, or has access to or interest in real or personal property supervised by the federal government. Architectural access does not mean that the entire structure has to be remodeled. For example, if a computer class is held upstairs and is inaccessible, one merely has to move the class downstairs, and not have to redo the physical structure of the building. Arbitrary requirements must be removed to meet current mandates. As another cited example, the State of California at one time required that all state employees must be able to drive state cars. Such a policy negated the hiring of blind executives, so the rule had to be changed. In other situations, a mathematics test was required for janitors, which was an unnecessary demand. Such positions could be filled by people who are mentally retarded when cans were color-coded, as one step in accommodation.

In interviews, one cannot query the individual regarding the disability, as this question has served as a screening device in the past. The questions asked of one applicant must be asked of <u>all</u> applicants. The employer has the responsibility of providing a working environment which will allow the person to function in the job.

There are myths concerning people with disabilities. A not-very-nice person who is suddenly injured in a vehicular accident does not immediately become saintly—the "Helen Keller syndrome."

People with disabilities are like other people with the same swings in attitude or differences in personality and should be treated by the supervisor as are other persons. Another myth indicated that if one becomes disabled one becomes incompetent and thus not too bright. This belief is given substance in restaurants where it is a common experience of persons who are blind to have their companions asked by the waiter, "What will he have?" or in one instance to have the question spelled as is done frequently to avoid comprehension by a child. Or the opposite concept is held—one becomes blind and through super-compensation one develops radar and knows who is approaching 10 miles away. Allowances must be made for people as individuals and not in accordance with stereotypical myths.

In placement, Mr. Fleming believes in using the systems theory—taking a look at the entire system that is involved. Actually, reasonable accommodation has proved to be reasonable in cost. The average recommendation has cost about $300.00. In the systems approach one views the continuum—where does the person park his car; how does he get into the building; how does he get to the restroom; is the cafeteria line wide enough; can the job tasks be changed or traded?

Auxiliary aids are available to allow accommodation, and the Department of Rehabilitation can suggest the devices that will allow people with disabilities to complete certain tasks.

Under section 504, if one is a recipient of $25,000.00 in federal funds, one must notify participants, beneficiaries, applicants, and employees of required procedures through printed materials and designate a responsible employee to handle problems arising under the Section. All recipients, irrespective of amount, must assure that communications go to people who are visually impaired or hearing-impaired. Assurance of non-discrimination must appear on all applications and federal-assistance requests. One must prepare a self-evaluation on policies and practices with the assistance of organizations and persons concerned with disabilities and must eliminate barriers. If there are questions on reasonable accommodation, they can be placed with Mr. Fleming's office, telephone (916) 323-3078. For the location of specific devices, one can call the Job Access Network, (916) 323-2959, which functions under contract with the Governor's Committee.

Preparing Youth with Disabilities for the Job Market

With Dr. Paul S. Entmacher, Chairman of the President's Committee on Employment of People with Disabilities Medical Subcommittee serving as chairperson, **Ms. Jane Lugo**, from the Los Angeles Unified School District, discussed preparation at the secondary level. Project Work Ability is a unique program utilizing carefully designed linkages with the State Department of Rehabilitation, the Employment Development Department, and local school-district personnel. Over 64 school districts in California, with 10,000 students, are involved in this project. Success in such an undertaking requires careful assessment, training of the student, direct employer involvement, and motivated young people.

Vocational advisors introduce the program to interested students who are at least 16 years of age. Application for services is made to the Department of Rehabilitation. Following acceptance, contacts are made with the students, and career plans are devised. The job selected must be commensurate with both his or her interests and abilities. In working with youth with disabilities, the job must be fitted to the student, rather than molding the student to the job. Transition is accomplished through a variety of training modalities in the classroom targeted toward a work-ready, motivated plan. Training methods

include unpaid work experience, school stipends, private sector stipends, direct hire, job interview techniques, work attitudes, and job responsibility.

The placement coordinator, a newly classified position, is the most valuable nexus between employment opportunities and the student, and through contact with the employer community, makes known the need to hire persons with disabilities. Through knowledge of the legislative bases and of the particular limitations involved, misconceptions concerning the disability can be dispelled.

National data show that the average person with a disability will experience eight to 10 interviews before being employed. Through the efforts of the placement coordinators this figure has been reduced to two interviews, or frequently, a single review with the student. In 1982, emphasis was given to persons who are deaf and persons who are hearing-impaired, and because of its success, was expanded to include persons who are visually handicapped. Two years later, the program was broadened to utilize 16 pilot senior high schools, four occupational programs, and seven special education centers.

Ms. Lugo showed a series of slides illustrating placement of many of the young people who have disabilities. Students were seen working in a radiology darkroom, a retail ice cream outlet, with a roofing crew, in an auto wrecking company, as a dog groomer, and as box personnel in supermarkets. Particularly strong supporters have been Safeway Stores statewide and the Pizza Hut chain. Most jobs become known through word of mouth.

In substance, youth with disabilities can function effectively in the work force.

The preparation of young persons with disabilities for the job market at the university level was discussed by **Dr. Paul K. Miller**, Director of Handicapped Student Services at California State University, Fullerton. He indicated that the number of students with disabilities at the college level has increased in both the public and private institutions of higher education, because most jobs are currently requiring an undergraduate degree. Citing the Harris poll findings alluded to earlier, Dr. Miller indicated that we still have a large pool of untapped manpower in people with disabilities, and, in spite of the efforts of many organizations, we have not made significant progress. Four times as many working people with disabilities have a four-year college education in contrast to persons who do not work. Among the non-working segment, 43 percent did not complete high school, as compared with 22 percent of persons with disabilities who were working.

In a recent conference, it was given emphasis once again that the increase of the aging segment in our population will make greater demands for a fiscal support base. It is essential that minorities—including a large number of persons with disabilities—be added to the work force in order to bring reality to the funds required for the population shift. Any statistical reflection of the labor force covers only those individuals who are working or are currently looking for work, and does not include people with disabilities who are discouraged, particularly older persons, who are no longer seeking employment. The great number of students with disabilities presently in college with objectives ranging from an A.A. to a graduate degree fully anticipate employment based on their capabilities, and in no way related to their disabilities. Attitudes among the young have changed markedly for they look forward to strong, active competition with non-disabled people for the positions available. During spring recruitment, more employers visiting campuses are asking for student candidates with disabilities, and this move is not

motivated by any federal pressure, for, in this administration, efforts have lessened considerably in affirmative action. Much of the movement has risen from the positive experience in the recent past of employers taking on youth with disabilities.

The increase in technology that has made more assistive devices possible has added to the utilization of graduates with disabilities. Many students, still on campus, have a more roseate view of possible employment than actually exists in the working world. Campuses are accessible and there are support programs, which conditions still do not prevail with many employers. In indicating the persistence of negative attitudes, Dr. Miller read many letters to Ann Landers chiding her for supporting the case of the woman in a wheelchair in a restaurant, being fed by her husband. The points of view revealed attitudes toward people with disabilities redolent of total intolerance, Nazism, and the deepest of prejudice. There is still a great need for reversal of the revulsion expressed by such bigots, and this problem will be tackled by these young graduates when they become members of the working world.

Particularly in need of reasonable accommodation in the future are people with learning disabilities, a rather hidden population, whose exact number has never been tabulated. Superimposed on the disability are emotional problems which, jointly, will challenge any set of skills in accommodation.

A change in attitude among the medical profession is needed also, in the conservation of this important natural resource—our citizens with disabilities.

Dr. Miller, when asked how attitudes could be changed, related special sessions entitled "The Accessible Classroom," wherein faculty are exposed to the needs of students with disabilities. It is the objective to have the recalcitrant academician through seeing role models, as portrayed in video tapes, identify and accommodate the student with a disability. With this background, the faculty become prepared for the living experience of having students with disabilities in their classrooms. The program aims at increasing their sensitivity to.the needs manifested by different organ-system limitations.

He indicated further that students who are non-disabled and previously not known to him, have come to him on graduation to thank him for the opportunity of going to school with people with disabilities, getting to know them in the student Union, in the classroom, or in the cafeteria. This attitude is a valued product of the effort.

Identifying the Opposition—Where are the Roadblocks?

Spotlighting the opponents to the utilization of people with disabilities was assigned to Ms. Marilyn **Holle**, an attorney long identified with advocacy for people with disabilities.

The first of some of the roadblocks to be covered by the speaker was Work Disincentives. It is difficult to move an individual from the recipience of benefits to work independence. There is the "Self-Support Plan" which apparently is unfamiliar to most counselors in the Department of Rehabilitation. If used effectively it can move people from Social Security Disability Title 2 benefits or Title 16, the regular Social Security Insurance (SSI) benefits to begin work and become eligible for the Section 1619 benefits.

The second problem or disincentive is the failure of Social Security to implement the promise of section 1619, which has been in the statute books since December 1980. Only now has implementation begun. Because of the lack of implementation, a class-action suit was filed to require Social Security to review the cases of all persons disallowed benefits because of their working and who had not been evaluated in light of Section 1619's cash benefits; or had, by definition, demonstrated substantial gainful activity (SGA), by receiving a monthly wage of $300.00. In 1980, the SGA figure for people with disabilities was $300.00, and people who are blind, $400.00. In this current year, while the SGA level for persons who are blind has been increased to $650.00, persons with disabilities are still operating at a $300.00 sanction.

> Before adjourning on October 16, 1986, the 99th Congress approved legislation which included making permanent provisions of Section 1619 of the Social Security Act which authorized the continued payment of Social Security Insurance benefits to individuals who work in spite of severe medical impairment.

The Section 1619 program permits also the continuation of medical benefits without cost-sharing, provided one's income is not more than $200 above one's SSI benefit. Presently, legislation is being considered to rectify the lack of benefits accruing to persons with pre-existing conditions, which excluded coverage under many employers' group policies. The legislative effort is targeted, in addition, to benefits for the part-time worker with a disability. If passed, a significant protection will be provided people with disabilities. Included also would be those employees whose company changes insurance plans. While coverage would be provided during the gap period, there would not be coverage under the second group plan.

California pioneered in certain programs that removed some of the disincentives to work, i.e., the SGA-Medical Program and the In-House Support Services Program.

There are a few problems with the Vocational Rehabilitation Program, Ms. Holle continued. Federal legislation requires meeting the needs for the person severely disabled before services can be provided the person with a non-severe disability. This element was added at the time of development of the Section 504 regulation in response to considerable testimony to the effect that state departments were unwilling to use the money needed for, or to take the time required for, rehabilitation of the person with a severe disability so that they could be partially or fully self-supporting. This mandate, however, because of its ambiguity and lack of clarity, largely has been ignored in many states. It was believed by the Congress that the federal share of 80% in the joint rehabilitation programs would be devoted to restoration of the person severely disabled, and that the states would, somehow, find funding for the person non-severely disabled.

Another discrimination against the person severely disabled has been the requirement that, if in school, the client would have to carry a certain number of units. Curricular schedules, in many instances, did not permit such a credit load.

Of special concern -- particularly as it relates to people who are mentally retarded -- is the practice o "dumping" persons with cognitive deficits into the rehabilitation program on the theory that this is where this group belongs. Yet, this represents a dead end because of the time needed to render them capable of contributin g to the mainstream of society.

For Employers

Word is being awaited in the *Arline case, which is under consideration by the Supreme Court. The issue concerns the interpretation of "chronic recurrent tuberculosis" as a "handicap" under the Rehabilitation Act, and entitled to civil rights protection. The case is of importance as it relates to other medical conditions subject to recurrence, where there are periods of relative freedom from symptoms alternating with periods of disability. (*3/87 ruling upheld interpretation.)

The recent position of the U.S. Department of Justice has been disappointing in regard to discrimination outside the scope of Sections 503 and 504, which precludes even considering an employment exclusion as justified. Many employers retain outmoded perceptions of many chronic disorders, exemplified primarily by epilepsy. Typical of this irrationality in argument would be the statement, "I didn't hire him because of his disability. I didn't hire him because of his noisy wheelchair." This point of view would be supported by the Department's interpretation. It is hoped that the Supreme Court will rule adherence to the full spirit of Section 504.

The disabled community can be divided into persons with visible disabilities and individuals with invisible disabilities, for different strategies can apply. In the first group, the impairment is obvious to the interviewer facing the job applicant. In keeping with our current school system arrangements where students with disabilities are educated separately, the personnel interviewers most likely have not had real-life experiences in dealing with persons possessive of severe and obvious disabilities.

Such an applicant is advised to write out a full explanation of the impairment, including the strategies developed to deal with the problem, answering in advance the question which the employer is too shy to ask.

In connection with the invisible disabilities, the applicant is to assume that the interviewer is asking only lawful questions—"What are the problems of your disability that could affect your work?" This query should be responded to truthfully. Any questions concerning previous or pending workers' compensation claims are illegal. At the point of medical examination, though, there can be a discussion of any residual disability.

Matters of reasonable accommodation rarely arise at the application stage, possibly because the employer has "weeded out" the job candidate by other means. When there is an issue concerning accommodation, Ms. Holle recommends that the applicant be assertive in familiarizing the employer with a solution. The employer must make a "good faith" effort in accommodation. Costs can be a consideration. There may be a salary reduction agreement to cover the costs of accommodation, which, in a way, can be of assistance in obtaining Section 1619 benefits. A further advantage lies in the employee's not having to pay taxes on the cost of his or her accommodation. This technique is highly advantageous in covering attendant care, a reader, or even a wheelchair.

SECTION II

THE PLAYERS AND THEIR STRATEGIES

Facilitator Ruth-Ellen Ross, The President's Committee on Employment of People with Disabilities.

The Role of the Examining Physicians - The Contract Consultant and the Full-Time Occupational Physician. Jean Spencer Felton, M.D., Clinical Professor, Community and Environmental Medicine (Occupational Medicine), University of California, Irvine.

The Role of the Professional Nurse

The Occupational Health Nurse — Marsha H. Schwartz, R.N., M.S., Occupational Health Specialist, Saint Joseph Medical Center, Burbank, CA.

The Rehabilitation Nurse — Evelyn K. Rubey, R.N., C.I.R.S., Rehabilitation Nurse Consultant.

The Role of the Rehabilitation Counselor

In the Public Sector — Frank Velasco, Ph.D., District Administrator, Los Angeles Central District, State Department of Rehabilitation.

In the Private Sector — Ronald Harper, Ed.D., Certified Rehabilitation Counselor.

The Role of the Job Accommodation Network (JAN) and the President's Committee on Employment of People with Disabilities — Ruth-Ellen Ross, The President's Committee on Employment of People with Disabilities.

The Functions of the Governors' and Mayors' Committees for Employment of People with Disabilities — Catherine Baird, M.S.W., Executive Director, California Governor's Committee for Employment of Disabled Persons.

The Role of the Employer — Patricia Pfeiffer, A.P.D. Associate, Personnel Consulting Group.

THE PLAYERS AND THEIR STRATEGIES

ABSTRACT

This section traces employment from the turn of the century, to the Rehabilitation Act of 1973 with reference to the role of the Examining Physician, to today. There is discussion of the objectives of a good medical examination and the placement protocol of matching capacities and demands. The examiner must identify functional capacities, and be helpful to both the applicant and the employer. The physician must remember that the future work life of the individual is at stake and act with genuine concern. Physicians need to visit worksites to become familiar with the thousands of jobs presently standard in industry.

The next discussion deals with the role of the Occupational Health Nurse. Occupational Health nursing is a synthesis of public health practices and principles for the purpose of conserving, promoting and restoring the health of workers. The Occupational Health Nurse provides the necessary professional link between these workers and employers, supervisors, vocational rehabilitation counselors, and all other workers.

The next section deals with the Rehabilitation Nurse and discusses functions which include evaluation of needs, emotional and financial visitation to treating physicians, review of discharge plans, support in the execution of treatment and care plans, investigation of home facilities, and reinforcement of certain treatment modalities. Then the role of the Rehabilitation counselor in the public and private sector is discussed. The role of the Job Accommodation Network is discussed, as are the functions of the Governors' and Mayors' Committees on employment of people with disabilities.

The Players and Their Strategies

With Ruth-Ellen Ross of the Staff of the President's Committee on Employment of People with Disabilities serving as facilitator, the afternoon session was devoted to the roles of the specialists involved in both the rehabilitation process and the placement in gainful employment of persons with disabilities.

Ms. Ross reviewed the essence of the morning session and, in recalling the future of a service information society as depicted by Dr. Galbraith, indicated that for every single "high tech" job, there are nine so-termed "low-tech" jobs filled by the labor force as a whole and fully extrapolatable to persons with disabilities. Inferred from the comment was the possibility of jobs for all persons, irrespective of their unique impairments.

Presenting "The Role of the Examining Physicians—The Contract Consultant and the Full-Time Occupational Physician" was **Jean Spencer Felton, M.D.**, Clinical Professor of Community and Environmental Medicine at the University of California, Irvine, and a specialist in Occupational Medicine. He indicated that work is significant to all of society and is central even in our changing society, which was recounted earlier. Almost every contact is opened with the query of, "What do you do?"

Tracing employment historically, it was recalled that at century's turn, workers were selected in keeping with the brawn presented, and all the invisible deficits such as hypertension, heart disease, and the then-rampant tuberculosis went undetected. By 1907, the first examinations of prospective employees were conducted to establish a preventive medicine base, but not to effect any intelligent placement.

The good intentions were impermanent. On May 4, 1911, Wisconsin passed the first workers' compensation act, and examinations were instituted almost immediately in order to keep out both those who were disabled and who constituted a future risk—the principle of future risk being applied in most hirings. The rigidity in medical standards in employment remained almost until the 1970s. The sense of unfitness was given emphasis by the rejections for service during World War II, even though war production plants welcomed older workers, women, persons with disabilities, and persons declared "4F."

But at war's beginning the new concept of selective placement was given birth by Bert Hanman, working at a naval installation in the San Francisco Bay Area, who devised the idea of analyzing jobs and then matching an applicant's physical capacities against the physical and environmental demands of the position being sought. Through the efforts of Dr. Howard Rusk, it was being demonstrated, at the same time, that human restoration of persons who were severely wounded was conceivable, was possible and was feasible, and that it worked. With the war's conclusion, hiring standards returned to the exclusionary style of old.

Felton then brought the scene up to date. The Rehabilitation Act of 1973 turned the employment picture considerably around. Today's examining physicians try to identify functional capacities; anyone who is evaluating a candidate for work must be provided with knowledge of the environment in which the

applicant will be working. The job title carries little meaning and most examiners, particularly physicians serving as extramural consultants, have rarely visited a worksite to become familiar with the thousands of jobs presently standard in industry. It is the role of the company's personnel to provide the examiner with job requirements so that the medical evaluation is based on an insightful understanding of both the work demands and the applicant's abilities.

There must be eliminated, he contended, the desultory examination whichcomprises a fast review of the heart, the lungs, and the inguinal regions, and a measure of the blood pressure. While a good examination will cost more, such a program is less costly than a workers' compensation settlement. In recent years, with nurse practitioners performing many of the examinations, both the histories and the evaluations have improved.

The objectives of a good examination are threefold: to bring persons with disabilities into the labor market, to create the beginnings of a preventive medicine program, and to establish a base for future comparisons, following periods of exposure to work materials.

The examining procedure must be personalized. The examinee should feel, at its conclusion, that somebody cares, and that the protocol is not just one step in a ceaseless number of steps in hiring. One makes contact through touching, and this act is of particular importance to people with disabilities. Touching is so revealing of feeling to the person bereft of certain functions or segments of the body image. It shows no fear of contact and brings the examiner and examinee together, establishing a base of closeness, and paving the way for solid, believable follow-up examinations.

Rabindranath Tagore, the Hindu poet, put it this way: "Oh, grant me my prayer that I may never lose the touch of the one in the play of the many."

Something must be said about the community role of the physician. If one is lecturing to medical students, or serving in an attending capacity, one should rectify the concept that impairment means a diagnosis which is immediately equitable with disability. Rarely is the so-called "case"—the patient being seen—a well person who might be impaired. Adults are not seen, as are infants, in a "well-baby" setting. The basis of the student's newly acquired career philosophy is being able to diagnose, and then being able to treat. When presented with an individual who does not have a disease, something that can be tagged with a diagnosis, there is no interest for there is no challenge, and the time is viewed as wasted. This viewpoint must be reversed.

One must familiarize the young physician with the placement protocol of matching capacities and demands. Further, the information must be left with all cognizant persons that the medical conclusion reached is but one piece of information used in formulating the hiring decision, others being training, experience, test results, interview impressions, and so on.

Physicians are not, by any definition or precept, to be exclusionary, but to be helpful to the applicant, the employer, the program in wellness or preventive medicine, and to society. The examination is never a "routine" examination, for the applicant or the employee returning after illness or injury is investing his personality, his fears and his hopes in the findings resulting from that interface. By terming the procedure "routine," the examination is being demeaned and derogated in place of its view as a valuable service.

Persons living in Los Angeles are familiar with the erudite music critic, Martin Bernheimer, through his writings in the Los Angeles Times. Not too long ago, he wrote: "It happens in the best of orchestras, especially in the best of the busy orchestras, in that the enemy sometimes wins the battle. "Routine," he continued, "triumphs over inspiration, for the muse gets tired. What should be brilliant, emerges merely perfunctory, and nothing goes seriously wrong, but nothing goes excitingly right, either."

One cannot be perfunctory in the placement of people with disabilities who are entering the job market or returning to the arena of the injury.

The plea to the examining physicians—be they full-time in industry or outside consultants—is to consider this kind of protocol as a serious undertaking determining the future life of the applicant and to avoid the usual tone of theexamination mill that has characterized much of the evaluation process. The examiner, Felton concluded, must act with art and compassion, remembering that work can dispel anxiety if the introduction is one of skill and feeling andhuman warmth.

The Role of the Professional Nurse

Marsha H. Schwartz, R.N., an Occupational Health Specialist with the Saint Joseph Medical Center in Burbank, spoke on the role of the Occupational Health Nurse.

She opened by saying that the OHN has moved a long way from the "band-aid" nurse to a primary care provider at the worksite. While the beginnings were seen with Ada Mayo Stewart, the 1895 nurse at the Vermont Marble Company, the programs today range from the single-unit nurse to comprehensive health offerings. The nurse's progress has paralleled America's development from an agricultural society to one of industry and technology. Other influences on the change have comprised pertinent legislation, new regulations, and the professional expansion of nursing itself. Business philosophy has matured from the days when occupational injuries and illnesses were considered unavoidable accompaniments of work. The addition of new chemicals, physical agents, and manufacturing processes increased the frequency and severity of traumatic episodes on the job, so that workers' compensation acts were passed and professional health care personnel were added to the staffs of various companies. As managerial attitudes changed, so did the constituency of the labor force, with its becoming better educated and more sophisticated. The care for trauma moved on to prevention, health promotion, and wellness, and emphasis was placed on the environment, being given greater solidity by the passage of the Occupational Safety and Health Act of 1970.

She turned, then, from history to the OHN. Occupational health nursing is a synthesis of public health practices and principles for the purpose of conserving, promoting and restoring the health of workers. Included is the ability to identify the health needs of employees, their environmental hazards, and the potential for harm, to relate work exposure to illness and to organize, coordinate, and provide nursing care in a safe and efficient manner consistent with professional standards and organizational policy. Involved in the process is collaboration with workers, their families, unions, insurance companies, regulatory agencies, community agents, and other safety and health professionals. The practice is autonomous, self-directed, interdependent, and extremely self-motivated. It involves risk-taking and a willingness to be held accountable both legally and morally. Most often, the OHN is the first contact a worker has with the health service and the individual who will care for the presenting problem.

What are the characteristics of these nurses? In accordance with the findings of a 1985 survey of 95 percent of the American Association of Occupational Health Nurses, 98 percent are women, 87 percent are between the ages of 31 and 60 years, 68 percent became nurses through diploma programs, and 28 percent hold baccalaureate, master's, or doctoral degrees. Of the respondents, 19 percent have been certified by the American Board for Occupational Health Nurses. Another specialist within the group is the Nurse Practitioner who has advanced skills in physical assessment, decision-making, and problem-solving.

The functions of the nurse include primary care, such as emergency care of minor illnesses and injuries, transportation for medical care, follow-up, and rehabilitative care. In health assessment, every effort is made to match the requirements of the position to the capacities of the individual, the process being the job placement evaluation. These assessments allow early identification of health problems, establish baseline health records, and are performed in compliance with regulations, and may be conducted annually or more frequently as a medical surveillance program, because of exposure to specific work hazards. Other assessments comprise return-to-work illness, absenteeism control, pre-retirement, or pre-transfer evaluations.

The OHN will carry out plant walk-throughs in an effort to identify new processes or new materials, and to become familiar with the controls in use. Further, the nurse sees the employees at their work stations and observes their use of personal protective devices. It is important that the OHN be seen in the workplace apart from his or her being encountered exclusively in the health service. The nurse also serves on the safety committee, reviews accident reports, investigates hazardous conditions, and participates in safety and health training programs and disaster planning. Crisis intervention is undertaken when workers are experiencing interpersonal, family, or work problems, and effects referrals as needed. Health education is offered through a one-to-one setting or in the group format, particularly in connection with their understanding of the health effects of certain work exposures. This function may be required by regulation.

The nurse has managerial responsibilities in the development of a position statement, identification of staffing needs, supervision, program evaluation, budget formulation, the creation of a policy and procedure manual, the establishment of confidential health files, and the preparation of reports. In addition, specialized activities may be required such as hearing conservation, respiratory surveillance, or the population may indicate certain case-findings procedures. Nurses are placed in the full spectrum of contemporary businesses and industries.

Although 4 million persons with disabilities are at work, it is believed that another 1 million could be employed. Some of the barriers faced by persons with disabilities are transport, architectural, communicative, and attitudes of employers, their families, and even themselves. The desiderata of the Rehabilitation Act of 1973 were reviewed; and then certain people with disabilities, who had been placed successfully at the Saint Joseph Medical Center, were shown as being illustrative of a variety of physical limitations.

The utilization of persons who are disabled leads to certain advantages for the employee—job satisfaction, responsibility, autonomy, financial gain, and personal growth. The OHN provides the

necessary professional link between these workers and employers, supervisors, vocational rehabilitation counselors, and all other workers.

The Rehabilitation Nurse

This role in disability management was covered by **Evelyn K. Rubey, R.N.**, a rehabilitation nurse consultant, formerly an OHN. While in the former professional role, she was aware of the great gap in communication between managers and injured or ill employees who were away from their customary jobs. Finally, through new nursing connections, Mrs. Rubey was able to go out to such workers to identify the problems that might be accompanying their physical difficulties. In the case of one individual seen early in her transition, it was learned that seven physicians were providing care, but that there was no communication among them. Medications were not in congruence, the patient was depressed, and eventually, through urging, therapy was obtained for the detected emotional disruption.

Rehabilitation nursing began in the 1950s in some of the larger insurance underwriters. Much progress has been made since then and much has been learned. The functions executed by rehabilitation nurses include evaluation of needs—emotional and financial—visitation to treating physicians, review of discharge plans, support in the execution of treatment and care plans, investigation of home facilities including hazards to the person who is convalescing or who wears a cast, and reinforcement of certain treatment modalities.

A second large contribution is that of assisting in the return-to-work to the same or another job. In many instances at this stage, considerable anxiety and fear develop, and the rehabilitation nurse, by being the liaison between the recovering client and the employer, can allay much of the apprehension about the resumption of gainful employment. The rehabilitation nurse assists also in job modification so that the injured individual can return to work sooner than otherwise anticipated.

The costs of accommodation are relatively low in the total cost of the rehabilitation process, so that employer tax credits called for in legislation currently being considered would allow the worker to return to his old job, or to a modified position.

The third function is that of job analysis. This developed information is given the treating physician and the physiotherapist so that each knows what thejob comprises, and so that the therapist will have guidelines for the work-hardening process.

In essence, Mrs. Rubey underscored the prime contributions of the rehabilitation nurse—and emphasized by several illustrative cases—as meeting the post-injury problems and effecting a productive liaison with the employer.

The Role of the Rehabilitation Counselor

To cover this participant role in the public sector was **Frank Velasco, Ph.D.**, a District Administrator in California's Department of Rehabilitation. As an opening comment, Dr. Velasco indicated that a few years ago, the state department ceased providing service to the patient covered by workers' compensation

insurance, who then became a client of the private rehabilitation counselor. This division brought an end to some competition and better relationships between the public and private sectors. Currently, the Federal-State programs provide services to individuals documented as having physical or mental disabilities interfering with their ability either to obtain or maintain employment.

How is this objective reached? The rehabilitation counselor monitors the "case"—the individual seeking or being referred for service. He or she makes assessments, determines the appropriate resources, and develops a plan that will lead eventually to competitive full-time or part-time employment, or work in the home setting, including home-making. This newer emphasis has led to the striking of the term "vocational," from vocational rehabilitation, in favor of the more generic designation of "rehabilitation."

As the speaker sees it, the problem still rests with employers, for many of them believe that he, in rehabilitation, represents part of the criminal-justice system, and that his clients are former felons. The employers are in need of constant reminding of their obligation to affirmative action and the determination, in advance, of an individual's needs in placement. A difficulty is encountered also in the construction of new buildings where the designers and contractors are definitely aware of the constraints in eliminating architectural barriers but will proceed with a structure anyway for it will be easier. Then, when the issue has been in court, some minor modifications will be made. A few employers are creative, and will design jobs ahead of placement. An employer who is supportive usually has had personal experience in his family or in the community and the positive attitude carries over to his own sphere of influence.

Physicians keenly sensitive to rehabilitation can be extraordinarily helpful in planning for the person's work future rather than merely carrying out a surgical procedure oblivious to its relationship to gainful employment. Most helpful are anticipation and cooperation with other team members as they institute a plan that will minimize the functional limitations and maximize the potential.

Employers, oddly enough, in many instances, expect the State agency to bear the costs of accommodation. The effective counselor strives to have the employer "buy into" the process for, as in psychotherapy, it becomes more meaningful when the expense is borne by the recipient of the wage-earner-to-be. With an investment already made, the employer wants to be sure that the effort will succeed. On occasion, when accommodative equipment has been purchased for the employer and the client has been placed and later terminated, the equipment is retained, most often never to be used again.

Dr. Ronald Harper, a certified rehabilitation counselor, discussed the role of the professional in the private sector. Some of the constraints governing the public agency, such as financial limitations, apply to the practitioner counselor, for while tax monies for the agency might be limited, so are supportive funds from the employers' carriers. The objective is the same in both sectors—having the employer hire people with disabilities.

Dr. Harper cited some investigations pertinent to the problem. The first was completed in 1978 by the Human Resources Center in Albertson, New York, supported by the Rehabilitation Services Administration. Some 110 studies were reviewed coursing back 30 years. The significant findings concerning employers' attitudes are given in the conclusions: "The success of rehabilitating an individual for employment may rest ultimately on an employer's willingness to hire a person with a disability. Un-

fortunately, what an employer says about hiring practices, and what that same employer does when confronted by an applicant who is disabled may be quite different. Evidence suggests that about 60 percent of employers say they would hire workers with disabilities. Only one-third do so. In other words, there is verbalized intention to hire rather than actual hiring. Furthermore, the majority of employers lack direct experience with persons with disabilities."

The second study to be alluded to was published in March 1986 and was conducted by Lou Harris and Associates, at the request of the International Center for the Disabled. Surveyed were 1,000 Americans with disabilities, and the results of the study were cited by speakers earlier in the Conference, to wit, the underemployment of persons with disabilities was the greatest in any minority in the United States.

All types of efforts have been made—legislation, tax incentives, education—but still without success. With the budget trimming of the Federal Office of Contract Compliance by 50 percent in 1981, the strength of regulation enforcement was diminished remarkably.

Some employers have been supportive: the larger banks, the Xerox Corporation, Pacific Telephone Company, IBM, among others. They have loaned their executives to companies to assist in developing programs for the employment of persons with disabilities.

Dr. Harper implied that "something is not working" for here, 66 years after the passage of the first Rehabilitation Act (the Smith-Fess Act), we are still engaged in conferences and efforts to bring persons with disabilities into the labor force. The mode and desire for solution remains with the employers. He closed by citing an aphorism of philosophy Professor Kalish from the University of California system, "There are no answers; there are only questions."

The Role of the Job Accommodation Network (JAN) and the President's Committee on Employment of People with Disabilities

Ms. Ruth-Ellen Ross of the President's Committee on Employment of People with Disabilities staff followed, to review the functions of one of the sponsoring committees. California is the largest user of JAN, which is based in Morgantown, West Virginia, and which remains available from 8:00 a.m. until 8:00 p.m. to respond to calls from the West. JAN was employer-inspired, it is employer-oriented, and is one of the best investments for utilization of persons with disabilities in the labor market. One of the prime developers of JAN was Mr. Jay Rochlin, Executive Director of the President's Committee, in addition to the speaker. His former employer, AT&T, had been job-accommodating for years, but the lessons learned had somehow remained within company confines. Ms. Ross touched once again on some of the roadblocks to employment of persons with disabilities—counterproductive attitudes, fear, uneasiness, and lack of personal experience.

JAN arose from a general lack of knowledge as to how to effect reasonable accommodation. Employers had become familiar with the hiring of other minorities, but had little insight into the steps needed to bring people with disabilities into their plants. JAN is not a threat to rehabilitation as thought by some agencies early in its inception. JAN is a counseling service using Human Factors Counselors and a computerized data base of job accommodation information. It is accessed by a free "800" number, and

is open to anyone who wishes to call in and learn what a person with specific functional limitations needs to accommodate to those limitations in order to do a specific job of work. Two elements are needed—a)a job and b) an applicant with discrete functional limitations. The naming of a generic disability will not produce any information, for the key lies in the indication of the particular limitations manifested by or detected in a work candidate. There are over 6,000 items in the files, over half of which were gathered from employers. Within the past two years and two months there have been over 4,000 inquiries. JAN is a bridge between enlightened employers in the United States—and what they have done—and prospective employers in need of that accommodative body of knowledge. There is no cost involved.

The kinds of calls received have been divided as follows: 40 percent new hires; 43 percent retention; 5 percent promotion; and 11 percent for work status improvement. The information is provided by staff members and not tape recordings. JAN is accessed in addition by persons with disabilities wanting to know how to get information to the employer. They are told to give the telephone access number of 1-900-JAN-PCEH, or 1-800-526-7234. Over a quarter of the responses given concern products to meet specific limitations. Eleven percent of the calls involve referral to other agencies; 7 percent relate to work activity accommodations; 5 percent concern computers; and 2 percent involve changes in the work station.

The disabilities represented in the requests have been as follows: Sensory, 30 percent; motor dysfunction, 40 percent; neurologic impairments, 8 percent; multiple disabilities, 8 percent; general disabilities, such as heart disease, diabetes, 5 percent; mobility questions, 5 percent. Inquiries have been received from Canada, in addition to everywhere in the United States.

JAN is presently supported by Federal money, with the hope that subsequent years will see support from the private sector. The information is there; it only remains to be sought.

The Functions of the Governors' and Mayors' Committees for Employment of the Handicapped

Committee roles were reviewed by **Catherine Baird, M.S.W.**, Executive Director of the co-host California Governor's Committee. she pointed out that the Committees continue to operate, seeking to reach the goals implicit in their titles, even though the policies and the players may change, and the legislative mandates may be interpreted differently as time moves on. These volunteer bodies comprise persons who care and represent diverse individuals, coming from different professional and community sources.

The California Governor's Committee was established in 1947, the year of creation of the President's Committee, in response to the President's request that all states develop such parallel groups. It was a time when veterans with disabilities were still returning to employment, only to find that employers were not giving them the opportunity to work. With the years, the target population has changed and the incidence of disability has risen incredibly. In California, the Committee serves under Executive Order, the members are appointed by the Governor, and staff support is provided primarily by the State Department of Employment Development and also by the Department of Rehabilitation. The most significant work is done at the grass-roots level by the Mayors' Committees that comprise singularly dedicated volunteers whose attendance or work costs are in no way reimbursed. The Governors'

Committee provides the forums for action by the local committees, as exemplified by this meeting and the quarterly sessions held regularly at different sites within the State.

In these conferences, the practical difficulties encountered in the hiring of persons with disabilities can be aired, such as time differentials in employment, the costs of accommodation, and the like. The Committees must maintain vigilance over compliance with the legislative requirements, for even though there are laws and regulations, unless there is some kind of watchdog present, they will be misinterpreted or there will be neglect in meeting their considerations. Further, the Committees work to reverse the contemporary myths and stereotypes concerning persons with disabilities and some of the negative attitudes expressed directly or covertly by certain employers.

Baird gave emphasis to the need for social integration of various committee members so that needs can be voiced and ideas exchanged among people of different disciplines. Persons who are interested in participating are invited to make contact with their local committees, for their contributions of thought and time are always welcome.

The Role of the Employer

Completing the discussions of the participants was **Patricia Pfeiffer**, an Accredited Personnel Diplomate. After relating considerable experience in the preparation of guidelines in employee selection and telling of the goals of many professional human resource associations in facilitating the employment of persons with disabilities, Ms. Pfeiffer outlined some of the steps to be taken relevant to the hiring of persons with disabilities.

There must be a raising of awareness or consciousness among employers. Emphasis must be given the skills of the person with a disability rather than the positive image accruing from the hiring, say, of a person in a wheelchair. Unfortunately, appeal still lies with the highly visible use of assistive devices by the person who is physically limited; but, if such a person can serve to open a program with a new employer, the ploy can be used.

Entry should be made, if possible, into the strategic planning or goal-setting office of a corporation, for an approach to any other personnel-using department will find that a new venture—rehabilitation, for example—will not have been budgeted, so that introducing a new program at that time and in that place will prove to be infeasible.

Next, one should assess the organizational climate early in the placement effort. Coupled with this evaluation is the need to have job-ready applicants immediately available, for personnel officers are judged by the speed with which they can fill a job requisition. As many agencies will take three weeks or more to prepare a candidate, the corporation will seek its employees elsewhere. There has been considerable success in applicant-readiness because of special programs for students with disabilities in both the community- and state-college systems, even exceeding the immediate availability of the non-disabled job-hunter. Such students are highly motivated and have had the experience of getting around crowded campuses and have had the guidance of excellent vocational counselors in both career selection, training and career development.

Once the one-on-one contact is established with the employer or his human-resource facility, then the relationship will facilitate greatly the placement effort, for each of the two people have come to know each other's needs and goals. Attending conferences of members of related disciplines will further these steps in acquaintance, and aid in personalizing the referral and placement process. A unique recruiting device utilized by one Southern California company has been through the mechanism of basketball games held between executives and managers—in wheelchairs—and job applicants similarly equipped. This meeting encourages quickly a commitment from the top of the organization.

Once an individual is hired and is on board, there must be follow-up so that supervisors and the peer-group workers understand special problems that might arise with the employee with a disability. No one, physically perfect or not, is a perfect fit in a job, so efforts at adjustment must continue.

When there are successes in a company, one should not hesitate in publicizing them, for the spread of the word will lead to other placements, or placements in other companies, once examples have been made known.

SECTION III

THE MECHANISMS

Facilitator Hershel Swinger, Ph.D., Professor of Counseling Education and Director of the Southern California Child Abuse Prevention Training Center, University of California, Los Angeles.

Medical Standards for Employment-Contemporary Criteria and How They Grow — James Johnson, J.D., President, Occu-Med.

A Return-to-Work Program — Thomas F. Torpy, M.P.H., Chief, Rehabilitation Service, Chief Administrative Office, Human Resources, County of Los Angeles.

A Union's Program in Employment and Retention of Workers with Disabilities — Charles E. Bradford, Director of Apprentice Employment and Training Programs, International Association of Machinists and Aerospace Workers.

Placing the Difficult-to-Place Job Applicant

Persons with Disabilities — Reynold T. Schmidt, M.D., Corporate Medical Director, UNOCAL Corporation.

Persons with Emotional/Mental Disorders — Homa Mahmoudi, Ph.D., Clinical Psychologist in Private Practice.

THE MECHANISMS

ABSTRACT

This section examined the mechanisms involved in the placement of persons with disabilities, and some of the attitudes among persons with disabilities. There was discussion of the Medical Standards developed by the County of San Bernardino and their implication for citizens with disabilities. Also there was discussion of the mainstreaming of persons with disabilities. An additional mechanism in the mainstreaming of people with disabilities is a Return To Work Program. Costs have risen extraordinarily in worker's compensation, particularly the cost attendant upon the vocational rehabilitation aspects mandated in some states. A Return To Work Program can reduce these costs measurably. Every employee is treated comparably, irrespective of the genesis of the injury—occupationally caused or unrelated to work. The International Association of Machinists and Aerospace Workers gave an overview of the union's involvement in programs for persons with disabilities. The final papers discussed the placing of difficult-to-place job applicants, employees with diabetes and persons with emotional/mental disorders.

The Mechanisms

The second day of the program was devoted to a discussion of the mechanisms involved in the placement of persons with impairments and some of the feelings encountered among individuals with disabilities themselves.

Dr. Hershel Swinger from the California State University, Los Angeles, served as the morning's moderator. **Mr. James Johnson**, President of Occu-Med, an organization concerned with the development of medical standards in hiring and the provision of occupational health services, presented the topic, "Medical Standards for Employment—Contemporary Criteria and How They Grew." Although medical standards date to World War I, their contemporary use was initiated in the mid-1970s. Two social pressures began to be felt by employers at that time: the rising cost of group health plans—bringing the "wrong" kinds of employees into the work force was driving up the costs of various benefit packages; secondly, the demands of civil-rights activists concerning the rights of persons with disabilities. Further, with the passage of the Rehabilitation Act in 1973 and the promulgation of the regulations four years later, there was considerable concern in California, and in the country in general, regarding a fuller participation of society in employment.

A large Federal grant was given to the County of San Bernardino for the purpose of addressing the two concerns just mentioned. An advisory board was formed comprising various seemingly competing interests from the community—civil-rights activists, insurance representatives, employers, and the like, who tended to have different objectives. But on the completion of the project two years later it was found that these elements were actually not in competition. Everyone was reaching for the same goal—a vehicle to accomplish the common objectives,to bring people into jobs who should be working safely and effectively and to keep people, legitimately, from entering positions that would prove injurious to them. Subsequently, the method developed in the project has been used with some 200 agencies and companies throughout the United States.

By definition, a medical standard is a statement about a medical condition or disorder and its relationship to the ability to perform a set of tasks. Historically, medical standards have been used as screening devices, so that any variant from the so-called "normal" would lead to rejection for employment. Today, standards are different, being used as positive tools to bring applicants appropriately into jobs. Medical standards differ from physical standards in that they are statements about a level of health and the evaluation of an individual's capacity to perform a job safely. Physical standards concern a person's ability to perform a job at all.

The type of standard which, it is hoped, is being eliminated is the traditional negative statement wherein it is said that if a person has such-and-such condition, he cannot work or is unacceptable. Such proscriptions would include diabetes, hypertension, back disorders, etc. Rarely found were the statements framed positively, e.g., "Left hemi-block is acceptable." A second utilizable type of standard is the one that focuses on the exact requirements of the job. To derive such a standard a greater knowledge of a medical condition is needed and, probably more important is a broader understanding of the physical requirements of a job.

Too many examinations have been conducted in the past by non-physicians, frequently employment interviewers who injected their own preconceptions as they scanned an applicant, feeling, and stating, that the candidate was too old, too short, too tall, or was a woman, and thus would screen out the job seeker by a process of unscientific, often emotionally based discrimination.

Primarily in the public sector, a certain amount of job information is given the examiner, comprising usually a single page prepared by the personnel department. The descriptive material is brief with few clues, if any, as to the metabolic expenditures inherent in the job. With the use of medical standards, an effort is made to get as much information as possible into the examining process, for the physician conducting the evaluation commonly is a generalist and is not a specialist in cardiology or orthopedics, or in any other areas that relate immediately to work. The standards have been derived with the consultative assistance of specialists so that the information transmitted to the examiner includes data giving the precise levels of performance required in light of the particular clinical disorder presented by the work applicant.

While the beginnings of the mid-1970s project in San Bernardino County seemed to focus on medical standards as a screening device which would exclude certain individuals from employment, the philosophy changed with time, becoming more humanistic, aiming at mechanisms that would bring more people into the workplace. The process has become bi-phasic. First, the statutes are studied to identify the proscriptions laid down by the legislators. Secondly, the program is nurtured through the guidance given by the medical experts who provide contemporaneous wisdom.

The system identifies 19 physical abilities that might be utilized on a job, involving different kinds of strength, mobility, vision, equilibrium, hearing, and dexterity, among others. The job is evaluated to determine the extent to which each of these abilities is required, and the final evaluation is fitted to a seven-point scale. The higher the number on the scale, e.g., seven, the more demanding is the job of that particular ability. In developing the statistically-derived ratings that are used in the evaluation, examples are given of the kinds of jobs or physical efforts characteristic of that point on the scale—installing metal doors, painting a ceiling, loading cement, etc. With the information from these descriptive tasks, the examining physician can determine if an individual with a certain impairment can perform effectively in that position. If the candidate cannot be matched to the job demands, then it is determined in what way the applicant can be assisted in filling the job or in what manner the job can be changed to allow the individual to be employed in that particular position. Such analysis of the jobs allows for reasonable accommodation—change of the tasks, re-assignment of certain tasks to others, realignment of some functions—and the ultimate qualification of the applicant for the job being sought. The same process has been used in a rehabilitation mode, with an injured worker returning to work. Through the computer, jobs are identified that include tasks the returnee can perform.

In the course of standards development, environmental factors inherent in the job were introduced for consideration—work above floor level, high ambient temperatures, dust, electric shock potential, and others composing a list of some 23 such factors. A profile illustrative of such a work environment is drawn so that appropriate safeguards can be introduced into the job or the correct personal protective devices can be utilized.

Standards must be applied equally to all candidates. For example, a job rated on the scale as a 5 or 6 would preclude the placement of an individual with spondylolisthesis because of possible back injury. However, a job that is less demanding, say, a clerical position, would permit a person with that spine disorder to work, so the recommendation regarding hire can be made. With time, it was found that there are different levels of severity of this spine condition, so that with the lower grades of the disorder, more persons could be employed through a greater specificity in the analytic process.

Even though the standards may lead to either qualification or disqualification for certain jobs, they are objective and rationally based. In the long haul, they have allowed many individuals to be employed who, in former days, would have been summarily disqualified for work. Thus, the use of research-derived standards will allow a much greater entrance of persons who are physically and emotionally limited into today's work force.

A Return-to-Work Program

This additional mechanism in the mainstreaming of people with disabilities was addressed by **Thomas F. Torpy,** Chief of the Rehabilitation Service for the County of Los Angeles. In keeping with the adage that rehabilitation begins with the first treatment rendered an ill or injured person, one can say that the return-to-work begins at the time of employment. New employees must be impressed early that they and their skills and talents are needed, and if an illness or injury does occur, they are to come back to work as soon as it is practical to do so. The treating physician must be apprised of this philosophy, as is the affected employee. Such a planking is good business practice, and saves costs for both the employer and the individual.

Costs have risen extraordinarily in workers' compensation, particularly the costs attendant upon the vocational rehabilitation aspects mandated in California. A RTW program can reduce these costs measurably. Every employee is treated comparably, irrespective of the genesis of the injury—occupationally caused or unrelated to work.

Mr. Torpy then reviewed the development of the program in the County of Los Angeles. In 1979, a self-insurance program in workers' compensation was introduced as a cost-saving effort. Concomitant with this action was the introduction of a comprehensive occupational health program, and a rehabilitation unit was created to provide some conformity of the RTW efforts among the 52 departments. The staff members were, in the main, vocational rehabilitation counselors at the master's level who provided services centrally in this voluntary program, contacting physicians to clarify confusing work restrictions, performing job analyses when needed, and working with departments in job re-structuring in order to allow a return to work. If these efforts were unsuccessful, the staff would assist the individual in applying for a disability retirement.

In 1973, a County employee who was returned to work with permanent restrictions following a job injury filed for a service-connected disability retirement. The Retirement Board, a separate functional entity, found that she was not disabled, so that she was caught in limbo, between two disparate decisions. When the case reached Superior Court, it was the opinion that she had two choices, i.e., disability retirement or the job, and the decision of the Board was the primary selection. This action made the

Retirement Board the final arbiter; the plaintiff had to return to a job which, by workers' compensation directions, she could not perform.

Shortly after this decision, Proposition 13 became law, resulting in the reduction of department budgets and the loss of positions. Concomitant with this passage there was a period of recession and employees wished to return to jobs within the County, but were unable to do so because of the change in the fiscal base. The State Legislature passed Labor Code Section 139.5, recognizing after nearly 60 years, that the intent of the original Workers' Compensation Act was a) to provide benefits to the injured employee, and b) to provide services that would aid in the individual's return to work. This legislative act strengthened not only the County's RTW program but that of many other large employers.

In the program, there are two major areas of activity. The first concerns the employee with temporary work restrictions. In effecting a RTW, the operational needs of the department must be recognized while affecting job modifications, and temporary assignments will be made available as often as possible. If returns to work are carried out with temporary work restrictions, the involved employees get their regular pay, and no additional personnel actions, such as re-classification for example, are required. It has been found that most departments need little assistance in temporary placement, irrespective of the nature of the illness or injury or its occupational relationship. The employee who has sustained a non-job-related episode is eager to get back to work because the benefits are limited when compared with those under the workers' compensation system. On occasion, the attempted RTW is premature, and on physician's counsel, additional convalescent time must be taken.

The occupationally ill or injured employee presents other problems. There is better economic protection; many litigate their claims and conflicting medical information emerges; some co-workers and supervisors question the reality of the injury; and the complaint is heard among managers that "they will be liable," presumably for some untoward event taking place on the RTW. Infrequently, an additional claim will be filed, which is in keeping within the employee's rights. Further, the department may not be able to accommodate the individual in light of the work restrictions, some of which do indeed challenge compliance.

The continuing counsel given departments is to treat everyone alike, to do things correctly, and, certainly, to be positive in attitude. The old feeling that such a returning employee is to be punished must be eliminated.

With individuals requiring permanent work restrictions, a RTW is a good business practice. As reported by the Workers' Compensation Institute, the average cost of rehabilitation under that system is about $15,000, is lengthy, and usually it is the client whose case is the most costly who does not return to work. The least costly form of rehabilitation is returning the worker to the same employer, in a modified or reassigned job, the cost coursing about $2,000. The charges include temporary disability payments, job analysis, and medical reviews. The process is effective, inexpensive, and rapid.

The RTW program started in 1979 when the California Supreme Court ruled that public employees were entitled to vocational rehabilitation, and the Chief Administrative Officer of the County requested that each department designate a responsible person as the RTW coordinator. In the larger departments, new full-time positions were created, while in the smaller departments, usually a personnel technician

assumed the additional duty. A training program was developed by the central unit, and each year the program is updated, and new coordinators are trained and given the RTW manual. On an annual basis, each departmental program is reviewed.

There are problems in effecting such a program. Information is lacking about what people can do within their limitations. Also, most persons do not understand the meaning of the rating, "Permanent Disability," frequently assuming that such a rating equates with ineffectiveness. The term, when used with a percentage, say 60 or 70 percent, implies that the individual with those limitations cannot fill 60 to 70 percent of the jobs in the labor market.} Much of rehabilitation is interpreted erroneously as training, and the intent of the law is not to retrain the 40- or 50-year-old worker in a totally different field, but to return him or her to the job in which he or she was incumbent.

For success in a RTW program, there must be a declaration of policy, by the organization; identification of handicapping conditions; and the establishment of timetables and goals for the central unit and departmental managers. If year-end bonuses are granted managerial personnel, the success rates in rehabilitation and RTW can serve as criteria in the award process. Staffs must be trained and refreshed yearly. There must be on-going oversight, and statistics of the operations must be maintained to demonstrate the usefulness of the program.

Such an undertaking should be part of every employer's effort in hiring people with disabilities.

A Union's Program in Employment and Retention of Persons with Disabilities

One union's activities in utilizing persons with disabilities was related by **Charles E. Bradford**, Director of Apprentice Employment and Training Programs for the International Association of Machinists and Aerospace Workers, based in Washington, DC. Union activities date back to the public employment acts when people who were disadvantaged who had no work experience were being brought into the labor force. The mythology of the time embraced a conception that we, the employers, would hire such workers, but "the union wouldn't let us." On investigation it was found that the union was neither notified nor asked about the program. further, most problems that did arise were readily resolved. There is a public misunderstanding of employer-union relationships in that many believe that relationship to be constantly adversarial. Most negotiations do not end in work stoppage, and, frequently, with long family-owned companies, agreements are reached with a handshake.

There are companies, however, who would like to eliminate the unions, and there is a daily struggle by the workers to maintain the dictates of the contract and the agreed-upon working conditions. In such organizations, the relationship will always be adversarial. When an employer comes to the union with a program that requires cooperation, labor wonders as to the motivation and remains skeptical.

The IAM has been involved with workers with disabilities since the early 1950s, and when the President's Committee inaugurated its awards program, it was the IAM that provided the program's first support and assistance. In the Los Angeles area, the International Guiding Eye was founded and supported by the machinists. Each year, the IAM supplies 60 guide dogs and the training at no cost to people who are visually impaired.

In 1980, the Project With Industry was initiated. Early on, the union was active in an offenders' program, finding jobs for them either when placed in work-release programs or when freed from prison. There was considerable success at that time. It was felt that if an employer would hire a murderer, a rapist, or a thief, he would surely employ individuals with disabilities. The IAM wanted to have its own program so Bradford left the AFL-CIO to join the machinists in this effort.

The program was started in Seattle where there was a good relationship between the employer and the union. In the Project with Industry program, the IAM worked with all agencies in the area, targeting their activity primarily toward the placement in industry of persons who are severely disabled of all ages. The initial program has been expanded into 17 projects throughout the United States. In California, there is one in San Francisco and one in Los Angeles. Many of the projects have been funded by the Rehabilitation Services Administration—in Seattle, Wichita, Dallas-Fort Worth, Kansas City, Chicago, Cleveland, Norfolk, and the Hartford-New Haven area. The PWI program utilizes the resources and the relationships the union has to assist in the hiring of people with disabilities.

The union "goes beyond the gate," for it supplies support services in the plant. Difficulties and biases between people are ironed out, and through a buddy system, the placed individual is helped by a shop steward or other union members. The film that the IAM has produced illustrates much of this kind of supportive activity.

The IAM has 8,000 collective bargaining agreements in the United States covering its 800,000 members, with strong representation among service personnel for the airlines and aerospace workers, the trucking industry, the auto mechanics, and the tool-and-die makers. The union, through these relationships, can get doors opened by its business representatives, and when entry is not feasible, the agent always seems to know or find an alternative approach.

Three projects, in Seattle, Los Angeles, and Chicago, composing the Transitional Youth Program, are aimed at finding employment for young people who have finished their school training. Four special projects are interactive with the Social Security Administration, particularly with recipients of Social Security Disability Insurance. Many persons, because of work-related injury or other trauma, lose their jobs and do not want to receive SSDI. The IAM is working with such individuals, helping them find alternative employment.

In all these programs, about 1,000 persons are placed each year. Services have been provided to over 6,500 people. Salaries range from $8,000 to $46,000, and the IAM works with both unionized and non-unionized companies. The average wage is about $14,000, which means that the workers placed are able to share in the benefits packages. The retention rate is nearly 80 percent, and the individual is not counted unless he has been on the job at least 60 days.

The program is cost-effective, for during the past year the wages resulting from the placements exceeded $10 million. The $2 million which accrued in taxes about paid for the costs of the program—money put in by the federal government, not including the monies contributed by the IAM. The AFL-CIO has a comparable program.

The union has developed a film, "We Can Do It" (which was shown at the conference), which tells the stories of six workers with disabilities who have gone back to work. The film dispels many of the myths

relating to work by persons with disabilities. It is being supplied to television stations throughout the United States and has been viewed already by over 2,000,000 people. Although thought initially that it would be shown only by the public stations, it has been used by the large networks. In cooperation with United Airlines, a 10-minute film, an excerpt from the longer film, has been produced for employers. Video cassettes can be obtained from IAM's area personnel. (Mr. Bob Hall, 213-483-1641; for the Transitional Youth Program, Mr. Bob Peters, 213-483-0114; Ruth Scott, 213-483-0509.)

The audience was invited to learn more of the programs through IAM's local staffs.

Placing the Difficult-to-Place Job Applicant

As persons with certain disabling conditions have proved difficult to place in gainful employment, it was believed helpful to have two of the more commonly presented disorders reviewed. The first of the pair, Persons with Diabetes, was discussed by **Reynold T. Schmidt, M.D.**, Corporate Medical Director for UNOCAL (formerly Union Oil Company of California). As background, Dr. Schmidt pointed out that the Corporation is multinational, 32nd in the Fortune list of 500, employing 20,000 employees working in 34 states and 13 foreign countries. Persons representing many disabling conditions are employed in all of the company's work locations.

For some years, UNOCAL has been placing persons with various chronic health problems in positions commensurate with their physical and emotional abilities. There are now nine full-time physicians in the United States and one overseas, in addition to a cadre of physician's assistants and nurses who communicate directly with managers at all levels concerning placement.

In connection with diabetes, two distinctions are made—persons with insulin-dependent diabetes, and individuals with the disorder but not in need of insulin. Applicants in the latter group are placed as is anyone without a chronic impairment, thus needing no further elaboration at this point.

Persons who are insulin-dependent cannot predict in the morning or afternoon when they inject themselves with insulin what the reaction might be. (The company, in its daily operations, presents many potentially hazardous work situations. In the production of energy there are fluids under high pressure, hydraulic lines, electricity, refineries, chemical plants, explosives and inflammable materials in transport throughout the United States and abroad. Employees work on ships, trucks, and planes. The ordinary truck tanker holds 10,000 gallons of flammable gasoline. The explosive part of one gallon of gasoline is equivalent to one stick of dynamite.)

Five restrictions are used in relationship to employees with insulin-dependent diabetes and are applied on an individual basis. The first limitation is that such individuals shall not work around moving equipment or machinery. There are certain work locations where equipment is unshielded and others where moving machinery is half as high as the conference assembly room, comprising power wheels, belts, and hydraulic lines. If an individual were to slip just momentarily, he could become entangled and killed. Such large equipment is operated by means of switches. There are compressors with pistons two feet in diameter and towers for distilling chemicals out of oil that rise 200 feet into the air. Care is taken not to place an individual at risk, should he or she have a lapse of consciousness, however brief.

Second—such an employee should not work alone. There are many worksites where people report in at the beginning of a shift and are not seen again until they leave at day's end. Such sites include the oil fields or the extremely large plants. The third restriction requires that the individual not work a rotating shift. (Dr. Schmidt explained rotating shifts as follows: A worker would begin week #1 by reporting at 7 a.m. and working until 3:30 p.m. In the second week, he would begin work at 3:30 p.m. and leave at midnight. For week #3, he wouldreport at midnight and remain until 7 a.m.) It has been shown that insulin-dependent diabetes is actually aggravated by the stress that attends a moving shift schedule, through interruption of the sleep/wake cycle and the disturbance of the eating schedule. Such a shift change is extremely difficult to be followed by the healthy mature adult free from a demanding physical disorder.

The fourth restriction of not working at heights has been a difficult limitation to define, but the consensus was reached of six feet as the limitation, or the equivalent roughly to one's height. A fall from that height would not prove too injurious.

Finally, the last job proscription to be placed is that they cannot drive a vehicle larger than a pickup truck. Some organizations preclude the driving of all vehicles, but this poses an undue limitation, for legally they can drive their own vehicles to and from work. As long as the diabetes is under control, the employee is safe as a driver and has been proved to be in UNOCAL experience. As many of the company trucks travel between states, Department of Transportation regulations govern the drivers of those vehicles, and persons with insulin-dependent diabetes are precluded from interstate driving.

The restrictions indicated are not applied to all persons, but are placed on an individual basis, each employee being considered in light of the work that is assigned. Accommodation is undertaken where feasible so that few, if any, persons with insulin-dependent diabetes are subjected to all of the five limitations.

There has been no difficulty with this group of employees. They act responsibly regarding control of their diabetes. They check regularly with their physicians and they experience no excess in absenteeism or in the sustaining of injuries. There have been several arbitrations in which the restrictions were the issue, but in all instances, following detailed explanation, the company's position was upheld. If a long-service employee develops diabetes and requires insulin, the same restrictions, singly or multiple, would be applied. Every effort is made to monitor the workers and retain them as employees. The program has been singularly successful.

Persons with Emotional/Mental Disorders

The second group of job applicants that have faced difficulty in employment comprise persons with active emotional problems or individuals who have recovered from such disorders in the recent past. Discussing this aspect of disability was **Homa Mahmoudi, Ph.D.**, a clinical psychologist in private practice, but with long experience as a counselor in Los Angeles County's Occupational Health Service.

Dr. Mahmoudi opened by citing an old Chinese proverb, "If one doesn't change direction, one will end up where one has started." She indicated that much of the conference concerned the lifting of barriers to allow access to employment of people with disabilities. A deeper and more enduring problem is the

removal of barriers that prevent the emotionally ill individuals from being accepted at a worksite. Employment interviewers and supervisors have difficulty in accepting applicants or employees who state that when they were 20 they were hospitalized for "a nervous breakdown," they were alcohol-dependent, they were on drugs, they were depressed, or job stresses "got to them." it is considerably more challenging to modify this kind of attitude than to effect a physical environmental change to accommodate a bodily organ system limitation.

Unfortunately, persons with mental illness are viewed as moody, fragile, unpredictable, shaky, spooky, indecisive, and as possessive of various other denigrating characteristics. In a study of 2,500 sheriff's deputies in 1973, some of whom had cardiovascular disease, it was learned that none had reported any symptoms or any objective findings for fear they would be considered incapable of working and would be assigned to desk jobs. Today, the acceptance level has changed for cardiac disorders, but mental illness is at the same point that physical conditions were nearly 15 years ago.

If one reviews the telethons, jogathons, celebrity golf tournaments, and other highly publicized fund-raising events, one finds that they are centered around a variety of physical ills, some of which may affect but one-half percent of the population. Benefits are simply not held for mental illness, mood disorders, or schizophrenia. In one study it was shown that 12 percent of the adult population have had, or will have, an episode of depression sufficiently severe as to require treatment. In a special National Institute of Mental Health report on depressive disorders it was pointed out that depression accounts for 75 percent of all psychiatric hospitalizations and that in any given year 15 percent of all adults between the ages of 18 and 74 may suffer significant depressive symptoms. In terms of costs, this area of illness coursed between $300 million and $900 million.

About one percent of the population suffers from schizophrenia, seven percent from other psychiatric disorders, and if drug abuse and alcoholism are added, the percentage climbs to 25 percent. It is these individuals who require hospitalization or other care. With appropriate care people are now returning to work in a much shorter time.

Physicians return individuals to work with the recommendation that they be free from stress, yet fail to define exactly what is meant. Does the counsel refer to a noisy room, a heavy caseload, or a lengthy distance from home? With many persons, staying at home proved to be more stressful because of loneliness than returning to work. The physician must inform the health care unit at the workplace of the kind of support or assistance that should be provided.

In the County of Los Angeles, the Psychological Counseling Section—which included an Employee Assistance Program—would offer six or seven sessions to the returning employee so that there would be support following an emotional illness. Further, at the time of hire, one must judge an applicant in light of the job requirements. Some positions require isolation while others indicate odd work environments such as the Coroner's Office. While the results of the Minnesota Multiphasic Personality Inventory on such candidates might indicate some aberration, these individuals work out well in essentially differ- ent job surroundings or with different task demands.

The secrecy and mystery concerning mental illness must be removed so that it is viewed as any other illness is viewed, in that persons, after treatment, can return to work and function well. Pointed out was

the fact that eminent composers in the past—Beethoven, Mahler, and Schubert—suffered from mood disorders (manic-depressive illnesses), and when they experienced "highs," they produced Hallelujah, and when they were in their lows, they wrote a Requiem Mass, but the creativity continued. With the newer medications people can work and they must be brought into the work force.

A negative bias still exists in the hiring of the job applicant with a history of mental illness. In a recent study, when such a candidate was reviewed for possible employment, the choice was made of a person with paraplegia because of persisting denigrating views. The prejudices and discrimination remain.

SECTION IV

FEELINGS

Facilitator Jean Spencer Felton, M.D., Clinical Professor, Community and Environmental Medicine (Occupational Medicine), University of California, Irvine.

How Does A Person with a Disability Really Feel? The Psychological Consequences of Disability — Allen J. Enelow, M.D., Clinical Professor of Psychiatry, University of Southern California, Santa Monica.

Discussion with Panelists.

Where Do We Go From Here? (Summary Remarks) — Jean Spencer Felton, M.D.

FEELINGS

ABSTRACT

The main paper dealt with coping with disability and how one must get beyond the episode of grief that is part of the feeling of loss after one becomes aware of the disability. Finally, in a summary there is a plea for greater exchange among the concerned experts, so that the medical/vocational rehabilitation process would become a reality.

Feelings

The chair was turned over to Dr. Felton for completion of the program. The topic, How Does a Person with a Disability Really Feel? The Psychological Consequences of Disability, was addressed by **Allen J. Enelow, M.D.**, Clinical Professor of Psychiatry at the University of Southern California. With his opening comments he expressed his dislike of the term "handicapped," for he felt its meaning escaped him. Preferred was the designation "disabled," although the differentiation between "able" and "disabled" frequently is not clear. He who is able today may be disabled tomorrow. For example, there are 10,000 spinal cord injuries occurring each year, and not all are subsequent to daredevil activity.

Much work was done with groups involved in the care of chronic illness. Often one says, "I know how you feel," the comment being an expression of support. But one really does not know how anybody else feels. You can only know what you feel and you can only know what response is invoked in you by someone else. This fact was learned through the work done in health behavior in chronic disease—arthritis, diabetes, asthma, hypertension, kidney disease, hearing and visual impairment, stroke, cancer, neurologic disease, post-myocardial infarct state, multiple sclerosis, and cerebral palsy, as examples.

The problem lies with those of us who are—at the moment—able. The initial response is to withdraw from such persons for there is a sense of fear that something like this disorder could happen to oneself. Or, there is the sense of not wanting to be disturbed by the appearance of something that could indeed afflict one and is extremely threatening.

How does the person with a disability cope? Ultimately, coping is the manner in which the individual deals with the threat of perceived or actual harm or loss. When one has suffered a disability, both harm and loss are involved. In her original studies of dying, Dr. Kubler-Ross delineated certain stages of response which can be extrapolated to any situation involving irreparable loss. First, there is denial, followed by anger, for if one cannot deal with the anger, rehabilitation is extremely difficult to accomplish. Then the stage ofbargaining which is doomed to failure but which is a period that many continue with indefinitely. Following is depression, and eventually, though not always, acceptance, moving forward in an attempt to find new ways of living in the world. These responses do not necessarily occur with military precision or by the numbers; they may occur jointly or in any mode of succession. Some individuals may never get beyond the stage of denial, and that is not necessarily detrimental, for a certain amount of denial is good. The feeling that "I can overcome this" is a good feeling. In a study of post-heart-attack patients at the Massachusetts General Hospital it was learned that those individuals who were coping with the event through denial had a higher survival rate than those not doing so. The denial must be realistic, for one cannot deny that certain functions are gone, but one can deny that the illness will stop one from doing what one wants to do.

Anger is inevitable in any instance where there has been a real loss. Some can be good if it motivates one to do something about the situation. If it leaves one resentful of everyone who is not disabled, then the anger can be self-injurious. Bargaining is a natural part of life, and can be acceptable. Depression which persists over a long period of time can lead to withdrawal and regression which is not good. Drug dependence occurring after a disabling event is a reflection of depression and withdrawal, and a desire not to have complete awareness of one's feelings.

Coping, therefore, is how one deals with disability. One must get beyond the episode of grief that is part of the feeling of loss after one becomes aware of the disability. Then there is the acceptance and the two general styles of coping. One is the aggressive, attacking, assertive, fighting attempt, involving many psychologic mechanisms. The other is retreat, in which one goes into a dependent status, saying, since this has happened to me, now the world owes me support and a living—a failure ever to develop any degree of independence. Obviously, it is with the first strategy that one will succeed in overcoming some of the difficulties.

What is needed from the outside world to make this work? The most important thing in building self-confidence and self-esteem is positive reinforcement. One must have the experience of success to give one confidence. How does one give a person with a disability this feeling of success? The opportunity to work, the opportunity to feel self-sufficient, the opportunity to know that one can do for oneself builds self-confidence and increases one's coping strength.

To reach this goal one needs persistence and assertiveness by the person with a disability and more education of employers and prospective employers in the development of more open attitudes toward the utilization of persons with disabilities as exemplified by the earlier remarks of Dr. Schmidt. An intermediate step for persons prior to entering the job market who have been seriously disabled is involvement with the centers of independent living, of which there are 30 in California, and 11 in Southern California.

With a move toward independence and offering the opportunity of increasing experience of success, the maximum number of people with disabilities will be able to return to the ranks of the able, the independent, and the self-sufficient.

Summary

Dr. Felton summarized the deliberations of the conference by building on some of the comments of Dr. Galbraith and his view of the changing world. In today's economy we have seen the continuing efforts of corporate take-over as all of us move into the information/service society. It is this move, though, that should provide the greatest opportunity for persons with disabilities. It is encouraging to learn that youths with disabilities are beginning to get counsel and vocational direction, which for years was absent in most educational settings.

In identifying some of the roadblocks to the employment of people with disabilities, it was both enlightening and dispiriting to learn that some of the opposition lies in the legislative mandates and regulations promulgated to accomplish precisely the opposite. In the hours passed it was learned who comprised the professional team players and how a new system of research-based medical standards allows industry to place intelligently persons with limitations in positions meeting their capabilities.

It has always been a basic philosophy, Felton declared, that nearly everyone can work, with the possible exceptions of the individual with acute rheumatoid arthritis involving multiple joints and the person with terminal cancer.

Some problems remain. While specialists in occupational medicine are familiar with the work scene, it is the treating physician who should come to industry and commerce to see real work accomplished by real workers. Further, not all patients or clients receive the services of all the members of the treating team. Until one can bring to bear all the professional skills and capabilities which have been discussed, some of the clients will be given short shrift.

It seems strange that decades after the birth of rehabilitation, few people seem to understand what rehabilitation is and has to offer. It is hoped that this knowledge gap will be filled in the time ahead.

The unions, wherever they are in industry, must be involved through both the informal mode of normal interchange and the formal mechanism of "meeting and conferring." It is entirely feasible to work with both management and labor—it is not easy; it is walking a tightrope, but it can and must be done by those who are attempting to reach the goals which have been discussed.

A research study was conducted years ago at an air base when Felton was at the University of Oklahoma. Department heads and managers at other levels were asked if they would hire persons with certain disabilities which were named. Most of the responses were negative. But the interesting and revealing fact was that these same managers had had persons with those impairments working for them for many years. It is in such situations that the myths regarding persons with disabilities are created and nurtured.

The medical specialists are unfamiliar with rehabilitation. When they have made their therapeutic contribution they consider the patient finished, but the individual, unfortunately, is not ready to re-enter the work force. More interdisciplinary education is needed in the preparation of the person who is convalescing for the resumption of employment.

It is essential that rehabilitation counselors work more closely with the health-care personnel in the companies that have physicians, nurses, and the other occupational health professionals. Only through knowledgeable interchange—on a person-to-person basis—will good referrals be made that will hasten the often tedious routine carried on by people who do not know each other except through impersonal correspondence.

In substance, a plea was made for greater exchange among the concerned specialists, so that the medical/vocational rehabilitation process would become reality. Only through such a cross-fertilization will persons with disabilities become more numerous in the mainstream of America's industries.

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